COPD

Disease Management Plan

MAC LEGACY

CONFIDENTIAL & PROPRIETARY INFORMATION

MAC Legacy 2015

The policies and procedures provided in this book do not guarantee full compliance with state and federal regulations. All policies must be read, understood and implemented within the agency. All policies must be approved by the Governing Board. Policies should be reviewed on an ongoing basis. Agency should revise policies periodically for efficiency, safety and effectiveness.

CHAP VERIFIED

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CHAP Disease Certification Program Crosswalk

COPD

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COPD

Disease Management Plan

Best Practices & Interventions

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Best Practice Assessment and Interventions for COPD

The use of evidence-based best practices are recommended for positive patient outcomes. Disease-specific Clinical Practice Guidelines are essential to guide the clinician in excellent patient care while maintaining compliance for the agency. Use this Best Practice Assessmentand Intervention document as a resource as you care for the patient with chronic obstructive pulmonary disease (COPD). The assessing clinician will need to use clinical judgment and physician collaboration to meet each patient's unique needs. The assessment and interventions may require modification if all elements are not applicable to your patient or additional interventions and goals are necessary.

Additional Supportive Tools/Resources

MAC Legacy's *Guide to COPD for the Patient at Home* - Patient teaching tool
Global Initiative for Chronic Obstructive Lung Disease (GOLD): www.goldcopd.org
Center for Disease Control (CDC) https://www.cdc.gov/copd/index.html
American Thoracic Society (ATS): https://www.thoracic.org/statements/copd.php

COPD General information and Statistics

Chronic obstructive pulmonary disease, or COPD, refers to a group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema and chronic bronchitis. The Centers for Disease Control report approximately 15.7 million adults in the United States have COPD, and it was the fourth leading cause of death in 2018. Most patients with COPD must manage the disease on an ongoing basis. It is essential for patients to have the training and support they need to effectively manage the disease to decrease risk of hospitalization and emergency department visits due to an exacerbation.

How to use the Best Practice Assessment and Interventions document:

1. Implement this best practice assessment and interventions if the patient has a diagnosis of COPD. This diagnosis will generally be categorized in the **MMTA—Respiratory** clinical group or the **Resp 5** comorbidity group for PDGM.
2. Complete a comprehensive assessment of the patient with additional targeted assessment data as outlined in the "Assessment of the Patient with COPD" section of this document. Use the assessment data and physician/approved provider orders to determine the plan for care of the patient.
3. Determine the frequency and duration of visits. Recommendations listed in the 'Number of Visits' section is simply a guide and the actual frequency should be determined based on the assessment of the patient and collaboration with the physician/approved provider and any other members of the interdisciplinary team.
4. Use the 'Interventions and Goals' section to guide the care of the patient. The plan of care must be individualized. Add additional interventions and goals and remove the suggested interventions and goals that are not applicable to meet the patient's unique needs. This document is based on best practices of a patient with COPD. Not every intervention listed in this document has a goal as some suggested interventions fall under another goal or are directions to the clinician.
5. To ensure regulatory compliance and achievement of goals as outlined in the patient's individualized plan of care, the clinician should follow the plan of care and document progress or decline. Regulatory references are listed with the intervention.
6. Documentation in the patient's clinical record should address each intervention and goal with adequate description of the skill performed and progression to goals. Intervention documentation example: "Patient and caregiver instructed on the written action plan for worsening COPD symptoms." Goal documentation example: "Patient and caregiver verbalize complete understanding of the written action plan and the steps to be taken in case of worsening symptoms within 3 weeks."

Best Practice Assessment and Interventions for COPD

Assessment of the Patient with COPD

- Review medical records and ask patient/family about medical history, specifically assessing the following risk factors for COPD:
  - ⇒ Smoking or other tobacco use
  - ⇒ History of exacerbations
  - ⇒ Asthma / chronic bronchitis
  - ⇒ Coronary Artery Disease (CAD)
  - ⇒ Alpha-1 Antitrypsin deficiency (AAT)
  - ⇒ Family history of COPD
  - ⇒ Occupation
  - ⇒ Myocardial infarction
  - ⇒ Sleep apnea
  - ⇒ Exposure to secondhand smoke, occupational dusts, fumes, gases, indoor and outdoor pollutants
  - ⇒ Vaccination status—pneumonia, influenza, COVID primary and booster vaccines
- Perform complete set of vital signs and head-to-toe assessment of all body systems with an emphasis on the following:
  - ⇒ Respiratory status - Assess for:
    - Respiratory rate and quality of respirations
    - Dyspnea at rest or with activity
    - Wheezing or dry, hacking cough
    - Oxygen saturation with pulse oximetry at rest and after activity
    - Lung sounds - Crackles (rales) indicate fluid in the lungs - especially the lower lobes
    - Paroxysmal nocturnal dyspnea (PND) - Difficulty breathing at night
    - Orthopnea - Difficulty breathing when supine
    - Supplemental oxygen use
    - Use of CPAP/BIPAP
  - ⇒ Cardiac status—Assess for symptoms of coronary artery disease, congestive heart disease, and cardiac arrhythmias which may be associated with COPD
  - ⇒ Blood pressure (lying, sitting, standing BP to assess for orthostatic hypotension which increases risk of falls)
    - Hypertension may occur with COPD
  - ⇒ Pain or discomfort—Assess for
    - Chest pain
    - Unusual pain or discomfort in lower extremities or abdomen
  - ⇒ Weight - obtain a baseline weight and record weight at the same time each day
    - Weight gain of more than 3 pounds in a 24-hour period or 5 pounds in a week is indicative of fluid retention and swelling in lower extremities (ankles, lower legs, or feet), scrotum, or sacral area
      - Fullness in abdomen / increased abdominal girth
      - Neck vein distention

Best Practice Assessment and Interventions for COPD

Assessment of the Patient with COPD

- Perform complete set of vital signs and head-to-toe assessment of all body systems with an emphasis on the following: *(continued)*
  - ⇒ Urine output - A decrease in the frequency of urination and/or amount of urine can indicate decreased renal perfusion or dehydration
  - ⇒ Changes in mental status - hypoxia may cause:
    - Confusion or difficulty with problem-solving
    - Memory loss
    - Dizziness or lightheadedness
    - Restlessness or irritability
  - ⇒ Abdomen—Assess:
    - Abdominal softness, symmetry, tenderness, and bowel sounds
    - Recent history of nausea or vomiting
  - ⇒ Nutritional status—Assess for:
    - Poor appetite and hydration related to physical inability to retrieve food/drink or intentional attempt to decrease trips to the bathroom
  - ⇒ Activity level and tolerance:
    - Restriction of activity to avoid uncomfortable symptoms
    - Required assistance for safe ambulation, toileting, dressing, meals, medication administration, and other daily activities
    - Increased dyspnea, elevated HR or BP, or decreased oxygen saturation with activity
    - Ability to climb stairs if required in environment
    - Use of assistive device for ambulation
    - Ability to ambulate to the vehicle and get in and out - with or without assistance
  - ⇒ Mental Health—Assess for:
    - Anxiety
    - Depression/sadness
    - Lack of motivation
    - Sleep disturbance
    - Sedentary lifestyle
  - ⇒ Social factors—Assess for:
    - Access to essentials such as food, medications, heat/cool, companionship
    - Ability to pay rent, mortgage, insurance premiums, utilities, etc.
    - Transportation to medical care

Best Practice Assessment and Interventions for COPD

Medication Assessment of the Patient with COPD

- Document all medications the patient is taking (prescription, over-the-counter, vitamins, herbs and supplements). Ask patient to see all medications and reconcile with physician/practitioner's office note or hospital discharge summary. It is common for medications and dosages for the management of COPD to be adjusted to symptom management. Ensure the patient or caregiver understands the medication regimen and the signs and symptoms of each to report.
- Note any medications that may be prescribed for the management of COPD:
  - ⇒ Beta-2 Agonists
    - ⇒ Short-Acting (SABA)
      - Fenoterol
      - Levalbuterol
      - Salbutamol (Albuterol)
      - Terbutaline
    - ⇒ Long-Acting (LABA)
      - Arformoterol
      - Formoterol
      - Indacaterol
      - Olodaterol
      - Salmeterol
  - ⇒ Anticholinergics
    - ⇒ Short-Acting (SAMA)
      - Ipratropium bromide
    - ⇒ Long-Acting (LAMA)
      - Aclidinium bromide
      - Glycopyrronium bromide
      - Tiotropium
      - Umeclidinium
      - Glycopyrrolate
      - Revefenacin
  - ⇒ Combination Short-Acting Beta-2 Agonist Plus Anticholinergic in One Device (SABA/SAMA)
    - Fenoterol/Ipratropium
    - Salbutamol/Ipratropium

Best Practice Assessment and Interventions for COPD

Medication Assessment of the Patient with COPD

- Note any medications that may be prescribed for the management of COPD: *(Continued)*
  - ⇒ Combination Long-Acting Beta-2 Agonist plus Anticholinergic in One Device (LABA/LAMA)
    - Formoterol/Aclidinium
    - Formoterol/Glycopyrronium
    - Indacaterol/Glycopyrronium
    - Vilanterol/Umeclidinium
    - Olodaterol/Tiotropium
  - ⇒ Methylxanthines
    - Aminophylline
    - Theophylline
  - ⇒ Combination Long-Acting Beta-2 Agonist plus Corticosteroid in One Device (LABA/ICS)
    - Formoterol/beclomethasone
    - Formoterol/budesonide
    - Formoterol/mometasone
    - Salmeterol/fluticasone propionate
    - Vilanterol/fluticasone furoate
  - ⇒ Triple Combination in One Device (LABA/LAMA/ICS)
    - Fluticasone/Umeclidinium/Vilanterol
    - Beclomethasone/Formoterol/Glycopyrronium
    - Budesonide/Formoterol/Glycopyrrolate
  - ⇒ Phosphodiesterase-4 Inhibitors
    - Roflumilast
  - ⇒ Mucolytic Agents
    - Erdosteine
    - Carbocisteine
    - N-acetylcysteine (dietary supplement; not regulated by the FDA)

Other Patient Assessments:

- Assess the patient home and living conditions:
  - ⇒ Safety concerns in the home
  - ⇒ Accessibility
  - ⇒ Assistive devices available and in working order
- Assess the need for additional disciplines:
  - ⇒ Therapy for strengthening/endurance/home exercise program/energy conservation techniques
  - ⇒ Aide for personal care assistance
  - ⇒ Social services for community resources, financial concerns, medication assistance
  - ⇒ DME Provider
  - ⇒ Pulmonary Rehab
  - ⇒ Pulmonologist
  - ⇒ Psychiatrist
  - ⇒ Psychologist
  - ⇒ Palliative care
  - ⇒ Spiritual/pastoral care

Complete the comprehensive assessment and develop the individualized plan of care based on the findings. Consider all diagnoses, the primary reason for home care, and the level of COPD disease management by the patient or caregiver when developing the plan of care.

Best Practice Assessment and Interventions for COPD

Telehealth monitoring considerations:

- Oxygen saturations
- Forced expired volume in 1 second
- Blood pressure
- Heart rate
- Peak expiratory flow
- Pulse oximeter readings

Suggested Visit Frequency

Skilled Nursing Services

First 30-day billing period	Second 30-day payment period
4-5 visits	2-4 visits

Use these suggested number of visits as a guide when determining the frequency and duration of visits for each 30-day payment period. The assessment and interventions may be adjusted to meet the patient's need for more or less visits based upon the following factors:

- Comprehensive assessment
- Physician/approved provider orders
- Identified needs and acuity
- Comorbidities
- Other services needed
- Support in the home
- Patient/family goals
- Change in condition

Therapy Services

A patient who needs strength or endurance training may need the addition of therapy services. The agency must carefully consider the needs of the patient and availability of support in the home when determining if therapy services are needed. The suggested number of therapy visits is a wider range and will be dependent on the patient needs and ability to tolerate treatments.

First 30-day billing period	Second 30-day payment period
0-6 visits	0-4 visits

Social Work Services

Social services may be indicated when the patient's psychosocial needs cannot be met by other services. The suggested number of social work visits is typically minimal with supplemental communication by telephone.

First 30-day billing period	Second 30-day payment period
1-2 visits	0-1 visit

Home Health Virtual Visits

Consider the use of telehealth, telephone, or other methods for virtual visits as a tool in the care of the patient. Virtual visits are not billable under the Medicare benefit. However, these types of visits have proven to be effective in the care management of the patient in between in-person visits. Keep in mind that virtual visits, including telehealth, do not contribute to the LUPA threshold visit count.

Best Practice Assessment and Interventions for COPD

Interventions and Goals

Interventions	Goals
SN observation and assessment of COPD by analysis of weight, pulse, BP (lying, sitting, standing), pulse oximetry, spirometry, medication compliance, and signs/symptoms/ complications indicating unstable condition at each visit with possible need for change in plan of care. *MBPM: 40.1.2.1*	Patient's COPD will be free from exacerbation and patient will remain in home setting and not require hospitalization or emergent care for complications of disease process throughout 60-day episode.
SN to educate patient/caregiver on self-management of COPD by utilizing their written action plan. **Educate** on how to monitor and document weight, pulse, and blood pressure weekly. **Educate** patient/caregiver on physician-ordered or agency specific evidence-based parameters (if no physician-ordered parameters) of weight, pulse and BP. **Educate** patient/caregiver on use of My Action Plan-symptom monitoring and recognition and appropriate action. Use scenarios to practice decision-making of self-care based on Action Plan *MBPM: 40.1.2.3; GOLD*	Within two weeks, patient/caregiver will demonstrate understanding of COPD written action plan. Within three weeks, patient/caregiver will demonstrate compliance to self-management techniques.
SN to assess patient/caregiver knowledge retention of self-management of COPD including use of My Action Plan and compliance to medication regimen. Examine patient/ caregiver's documentation of weight, pulse and BP to assess compliance to self-management. **Document** specific knowledge deficits and reteach as necessary. *MBPM: 40.1.2.3 ; GOLD*	Within two weeks of documented re-teaching, patient/caregiver will demonstrate compliance to self-management techniques.
SN to perform complete drug regimen review to identify potential clinically significant medication issues of current medication including medication reconciliation, identification of potential clinically significant medication issues such as potential adverse effect and drug reactions that include ineffective drug therapy, significant side effects, significant drug Interactions, duplicated drug therapy and noncompliance with drug therapy. *SOM: 484.55(c)(5)*	Within 24 hours, any identified potential clinically significant medication issues will be reported to the patient's physician/allowed practitioner.

MBPM: Medicare Benefit Policy Manual, Chapter 7: Home Health Services
SOM: State Operations Manual, Appendix B—Guidance to Surveyors
Global Initiative for Chronic Obstructive Lung Disease (GOLD)
Center for Disease Control (CDC**)**
American Thoracic Society (ATS):